Florida Public Health Research Programs
INVOICE

DOH Grant #: ______________ **Invoice #:** ____________________

Date Invoice Received:

Date Revisions Received:

1. PLEASE SUBMIT ALL DELIVERABLES BY UPLOADING TO PEERNET.
2. INVOICES WILL NOT BE PROCESSED FOR PAYMENT UNTIL ALL DELIVERABLES ARE RECEIVED AND APPROVED.
3. ALL DELIVERABLES MUST BE RECEIVED PRIOR TO THE DUE DATE LISTED IN THE ATTACHMENT II, OR A FINANCIAL CONSEQUENCE WILL BE REDUCED FROM THE INVOICE (SECTION 5, TERMS & CONDITIONS)

Institution's Official Name and Address (listed on W-9):

Institution Name:

Street Address:

City, State, Zip:

Date Invoice Approved:
(Complete Deliverables Packet Approved)

Remit to Name and Address **(Must match remittance address in My Florida Market Place and Federal ID# plus sequence number associated with the Remittance address)**

Institution Name:

Street Address:

City, State, Zip:

Federal ID#: Include 3 digit Sequence Number

Financial Contact Name:

Financial Contact Phone:

DELIVERABLES **(Mark All That Apply - Must Match Terms & Conditions Attachment II**

Invoice	Quarterly	Final	**Period Covered**	**Invoice Amount**
Financial Report	Quarterly	Final		
Expenditure Report	Quarterly	Final		
Progress Report	Quarterly	Final		
Proof of Liability Insurance (see Attachment II for Due Date)				
Florida Legislature Progress Report	Annual	Final		

This grant provides research data with the goal of prevention, diagnosis, and treatments, to expand the foundation of biomedical knowledge and improve the health of Floridians.

FOR DOH USE ONLY

Financial Consequences Applied: ____________

Revised Invoice Amount: ____________

CERTIFICATION: By providing this electronic signature, I,

am attesting that I understand that electronic signatures are legally binding and have the same meaning as handwritten signatures, I am also confirming that internal controls have been maintained, and that policies and procedures were properly followed to ensure the authenticity of the electronic signatures. This statement is to certify that I confirm that this electronic signature is to be the legally binding equivalent of my handwritten signature and that the data on this form is accurate to the best of my knowledge.

______________________________ **Authorized Signature**

______________ **Date**

**** FOR DEPARTMENT OF HEALTH USE ONLY ****

SIGNATURE OF GRANT MANAGER/LIAISON:

______________________________ ______________

Grant Manager/Liaison, Biomedical Research Section *Date*

Public Health Research

By providing this electronic signature, I, ______________________________

am attesting that I understand that electronic signatures are legally binding and have the same meaning as handwritten signatures, I am also confirming that internal controls have been maintained, and that policies and procedures were properly followed to ensure the authenticity of the electronic signatures. This statement is to certify that I confirm that this electronic signature is to be the legally binding equivalent of my handwritten signature and that the data on this form is accurate to the best of my knowledge.

SIGNATURE OF SUPERVISOR:

______________________________ ______________

Deputy Director, Public Health Research *Date*

By providing this electronic signature, I, ______________________________

am attesting that I understand that electronic signatures are legally binding and have the same meaning as handwritten signatures, I am also confirming that internal controls have been maintained, and that policies and procedures were properly followed to ensure the authenticity of the electronic signatures. This statement is to certify that I confirm that this electronic signature is to be the legally binding equivalent of my handwritten signature and that the data on this form is accurate to the best of my knowledge.

All Deliverables approved on this Invoice are referenced on the Invoice Performance Analysis form and inclusive of the requirements of the Grant Terms & Conditions, Attachment II Payment Schedule (attached).